

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? () Yes (x) No
Requestor's Name and Address Presbyterian Hospital of Plano P O Box 910812 Dallas, Texas 75391	MDR Tracking No.: M4-03-7369-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Company 6210 East Highway 290 Austin, Texas 78723-1098 Box 54	Date of Injury:
	Employer's Name: Air Tractor, Inc.
	Insurance Carrier's No.: 99B0000283421

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
06/03/02	06/07/02	Hospital Admission	\$41,382.73	\$41,382.73

PART III: REQUESTOR'S POSITION SUMMARY

"If audited charges exceed \$40,000.00, carrier should reimburse 75% of total charges (134.401 C (6)). Per Stop-Loss rule, this method is to be used in place of and not in addition to per diem/Fair and Reasonable or any other method of audit."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response was untimely.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested additional reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed \$40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the information provided by both parties, it does appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does apply and the reimbursement is to be based on the per diem methodology described in the same rule. The requestor indicates in the operative report, that this was a posterior and anterior lumbar fusion. The patient taken to the recovery room satisfactory condition and tolerated the procedure well per the operative report.

The carrier made reimbursement based on per diem for the 4-day stay in the amount of \$18,116.49. The provider billed the carrier \$79,339.30 for the 4 day-stay and received \$18,116.49 in total reimbursement, leaving \$41,382.73 in dispute.

Per Rule 133.301 the carrier did not perform a line item audit indicating a recommended allowance.

Using the stop-loss methodology the total allowable WCRA is \$79,339.30.

The carrier has reimbursed the provider \$18,116.49.

Based on the facts of this situation, the parties' positions and the application of the provisions of Rule 134.401(c), we find that the health

care provider is entitled to an additional reimbursement for these services equal to \$43,382.73 total allowable WCRA \$79,339.30 x 75% = \$59,504.48 - \$18,116.49 already paid = additional reimbursement of \$41,387.99 However, the requestor has indicated on their TWCC-60 Table of Disputed services that the amount in dispute is \$41,382.73, therefore, this additional amount is recommended.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$41,382.73. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20 days of this Order.

Ordered by:

Allen McDonald

06/15/05

Authorized Signature

Typed Name

Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787 Austin, Texas 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____